KAMALA D. HARRIS
Attorney General of California
ALFREDO TERRAZAS
Special Assistant Attorney General
GLORIA A. BARRIOS
Supervising Deputy Attorney General
State Bar No. 94811
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-2540
Facsimile: (213) 897-2804
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **BERNADETTE LOUISE BOYLE aka** **BERNADETTE LOUISE BOYLE-INGELS** **9163 Tiburon Circle** **Atascadero, California 93422** **Registered Nurse License No. 404965** Respondent.	Case No. 2012-11 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

Registered Nurse License

2. On or about August 31, 1986, the Board issued Registered Nurse License No. 404965 to Bernadette Louise Boyle also known as Bernadette Louise Boyle-Ingels ("Respondent"). The registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2012, unless renewed.

JURISDICTION

3. This action is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2725 of the Code provides in pertinent part:

(a) In amending this section at the 1973-74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. It is the intent of the Legislature in amending this section at the 1973-74 session to provide clear legal authority for functions and procedures that have common acceptance and usage. It is the legislative intent also recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems that provide for collaboration between physicians and registered nurses. These organized health care systems include, but are not limited to, health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, clinics, home health agencies, physicians' offices, and public or community health services.

(b) The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:

(2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.

(3) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.

(4) Observation of signs and symptoms of illness, reactions to treatments, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

(c) "Standardized procedures," as used in this section, means either of the following:

(1) Policies and protocols developed by a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code through collaboration among administrators and health professionals including physicians and nurses.

(2) Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system which is not a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code .

The policies and protocols shall be subject to any guidelines for standardized procedures that the Division of Licensing of the Medical Board of California and the Board of Registered Nursing may jointly promulgate. If promulgated, the guidelines shall be administered by the Board of Registered Nursing.

(d) Nothing in this section shall be construed to require approval of standardized procedures by the Division of Licensing of the Medical Board of California, or by the Board of Registered Nursing.

5. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with Code section 2750) of the Nursing Practice Act.

6. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or

to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

7. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

8. California Code of Regulations, Title 16, section 1442, states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

BACKGROUND

10. From on or about January 12, 1987, Respondent was employed by Atascadero State Hospital, (ASH), located in Atascadero, California, as a registered nurse. All patients at ASH are male and have a mental disability and pose a threat to themselves or others. The majority of residents at ASH are remanded for treatment by the California Superior Courts and California Department of Corrections.

11. On or about September 24, 2001, Patient C.J[1] was admitted to ASH pursuant to Penal Code section 1026 having been adjudicated not guilty by reason of insanity. He was a 39 year

[1] Patient will be referred to by initials only for the patient's privacy. The patient's identity will be provided in discovery.

old, African-American male. On or about March 27, 2005, Patient C.J. was medically examined. His medical records indicated that he had a high cardiovascular risk due to hypertension (high blood pressure), hyperlipidemia (excess of liposin in the blood serum), and morbid obesity.

12. On or about May 26, 2005, Patient C.J. was placed on a treatment plan where he was to be placed in Full Bed Restraint (FBR) (leather locking wrist, ankle cuffs and a Posey belt attached to a hospital bed) on a time-limited basis in conformance with ASH's protocol due to his behavioral issues. Patient C.J. had engaged in hostile and violent outbursts, both physical and verbal.

13. Under ASH's protocol regarding FRB, patients are to be assessed after release from FRB for temporary removal such as showers, transfers to new units and any change in their condition.

14. On or about July 5, 2005, at 2:30 pm until on or about July 8, 2005, at 9:30 pm for a total period of 3 days and 7 hours (79 hours), Patient C.J. was in FBR.

15. On or about July 7, 2005, at 4:00 pm, Patient C.J. complained of chest pain.

16. On or about July 7, 2005, at 8:00 pm, Patient C.J. was released from all FRB to briefly shower after soiling himself. Another RN wrote in Patient C.J.'s chart that patient had an anxiety attack in the shower. Patient C.J. was feeling faint and was assisted to the bench by staff in a wheelchair. Medical Officer of the Day (MOD) was notified and Patient C.J. was to see physician in the morning. The RN noted that Patient C.J.'s vital signs were within baseline with elevated pulse rate of 118.

17. Patient C.J. did not see a physician the morning of July 8, 2005, as ordered.

18. On or about July 8, 2005, at 4:30 pm, Patient C.J. was transferred to Respondent's unit. Patient C.J. was released from FBR at the time of his transfer, placed into ankle and wrist restraints and escorted to the new unit. Patient C.J. was then put back in FRB.

19. On or about July 8, 2005, at 6:00 pm, Respondent noted that Patient C.J. had a panic attack.

20. On or about July 8, at 8:00 pm, Respondent noted that Patient C.J. skin was dry and ashy and that he was complaining of headache, anxiety and stated, "my blood pressure must be

up." The patient spoke with apprehension about having a stroke or heart attack. Vital signs for Patient C.J. were pulse of 107, respirations 20 and blood pressure 131/98.

21. On or about July 8, 2005, at 9:05 pm, Patient C.J. called out to a passing Psychiatric Technician (PT) telling him he was feeling bad and had a lot of anxiety. The PT found Patient C.J. looking worried, sweating and pulling at his wrist restraints. The PT removed Patient C.J.'s Posey belt and ankle restraints (left on wrist restraints) and assisted him to sit up so that the patient could dangle his legs over the side of the bed. The PT let Patient C.J. sit on the side of the bed for approximately 10 minutes. Patient C.J.'s shirt was drenched in perspiration. The PT assisted Patient C.J. to the bathroom. Patient C.J. said he didn't feel good, and not to let him die. Patient C.J. collapsed to the floor and had no pulse or respiration. Cardiopulmonary Resuscitation was initiated.

22. On or about July 8, 2005, at 10:42 pm, Patient C.J. died. The cause of death was acute pulmonary thromboembolism with the contributing factors of morbid obesity and prolonged FBR.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

23. Respondent is subject to discipline under Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that in or about July, 2005, while on duty as a registered nurse at ASH, Respondent committed acts constituting gross negligence, as defined in California Code of Regulations, Title 16, section 1442, by failing to properly treat Patient C.J. as follows:

a). Respondent failed to thoroughly evaluate Patient C.J. when he was transferred to her care;

b). Respondent failed to document speaking with physician regarding the continued need for Patient C.J. to be on FBR;

c). Respondent focused on Patient C.J's restraints rather than focusing on what the patient needed to do to get out of restraints, and/or any adverse effect of FBR on his medical condition;

d). Respondent knew or should have known that Patient C.J.'s risk factors of Patient C.J.'s hypertension, including obesity and diabetes were compromised by being placed in FBR for 79 hours;

e). Respondent knew or should have know that Patient C.J.'s condition required re-evaluation of medical and psychiatric treatment;

f). Respondent failed to evaluate Patient C.J.'s on an ongoing basis, especially as to any change in vital signs, need for medication changes, evaluation for a less restrictive environment and failed to request any review by a physician and/or supervisor;

g). Respondent failed to exercise critical thinking in the treatment of Patient C.J.,

h). Respondent failed to perform a thorough physical and restraint evaluation for Patient C.J., who was symptomatic for cardiac pathology, and had a prior history of risk;

i). Patient C.J. was on blood pressure medication and although there were three consecutive documented elevations in his blood pressure, Respondent failed to notify the treating physician of a rise in the patient's blood pressure; and

j). Patient C.J.'s vitals changed, yet Respondent failed to notify the treating physician of any change.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

24. Respondent is subject to discipline under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, in that on or about July 8, 2005, while on duty as a registered nurse at ASH, Respondent committed acts constituting unprofessional conduct, as more particularly set forth in paragraphs 10 through 23 above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License No 404965, issued to Bernadette Louise Boyle also known as Bernadette Louise Boyle-Ingels;

2. Ordering Bernadette Louise Boyle also known as Bernadette Louise Boyle-Ingels pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: July 8, 2011

LOUISE R. BAILEY, M.Ed., RN.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

LA2009602653
30816576.doc